866.744.0621 | MedVantxRx.com

MEMBER INFORMATION

MEDVANTX PHARMACY SERVICES
PO Box 5736
Sioux Falls SD 57117-5736

MEDVANTX® *Pharmacy Services*

Cardholder ID# (Refer to ID Card)

Group # (Refer to ID Card if applicable)

Last Name of Cardholder

First Name of Cardholder

Delivery Address (Street and Apartment Number)

City

State

Zip Code

Email Address

Daytime Phone Number

Date of Birth (MM/DD/YYYY)

Gender ☐ M ☐ F

Drug Allergies:

☐ No Known Allergy ☐ Codeine ☐ Penicillin ☐ Iodine ☐ Sulfa
☐ Aspirin ☐ Erythromycin ☐ Other

Health Conditions:

☐ Arthritis ☐ Glaucoma ☐ High Cholesterol ☐ Thyroid ☐ Ulcer
☐ Asthma ☐ Epilepsy ☐ Heart Condition ☐ Depression
☐ Diabetes ☐ High Blood Pressure ☐ Other

List any OTC, herbal, or other medications you take regularly:

PAYMENT OPTIONS

Payment is due with each order. **Do not send cash**. If you use a credit card for your payment, MedVantx will bill your credit card for your portion of the drug cost, any special delivery charges and any outstanding balance due.

Credit Card Type (Our preferred payment method for faster service)

☐ MasterCard ☐ Visa ☐ American Express ☐ Discover ☐ Use Credit Card On File

Account Number

Expiration Date

Security Code

☐ Please place credit card on file for future orders.

☐ Check or money order enclosed. Cardholder Signature: Date:

REFILL OPTIONS FOR FASTER SERVICE, PLEASE VERIFY AVAILABLE REFILLS AND CALL US TOLL FREE AT 866.744.0621.

Additional forms can be obtained by contacting customer service or by visiting our website.

Patient:

Rx# Rx# Rx#

☐ Please Fill Enclosed Prescription ☐ Please Put This Prescription On file To Be Filled Later

Notes to Pharmacy:

PLEASE READ AND SIGN TO COMPLETE ORDER

I certify that the information provided on this form is correct and authorize the release of information regarding medical history, treatment and prescription drug history to MedVantx Pharmacy Services.

Signature: Date:

To refuse generics check here (❑), AND sign and date.

MedVantx Pharmacy Services substitutes generics when they are medically equivalent to the brand drug prescribed by the doctor. Please sign and date the statement below if you DO NOT want to receive generic products. *"I understand that I have the right to refuse generic medications. I understand this may result in a higher cost to me, that I am responsible for payment, and that the drugs are not returnable. When my doctor prescribes a brand drug, I wish to receive the brand drug only and accept these conditions".*

Sign: Date: